DOCUMENT RESUME

ED 219 010 HE 015 252

AUTHOR	Newbold, Richard C., III; And Others
TITLE	A Training Program in Medical Communications for Foreign Native Medical Graduates.
SPONS AGENCY	Educational Commission for Foreign Medical Graduates.
PUB DATE	Mar 82
NOTE	29p.; Two pages containing "Rating Scale" are marginally legible.
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Acculturation; Clinical Experience; *Communication Skills; *Cross Cultural Training; Cultural Awareness; English (Second Language); Evaluation Methods; *Foreign Medical Graduates; Higher Education; Intensive Language Courses; *Interviews; *Language Proficiency; Language Tests; Medical Case Histories; Paralinguistics; Peer Relationship; *Physician Patient Relationship; Pilot Projects; Role Playing; Simulation; Sociocultural Patterns; Speech Communication; Teaching Methods
IDENTIFIERS	Dartmouth Rassias Method; Foreign Service Institute Interview

ABSTRACT

An intensive 3-week training program in medical communications skills for foreign native medical graduates (FNMG) is described. The program incorporates language and acculturation training via medically relevant, situational dialogues and role playing; training in medical interviewing skills with patient simulations; instruction in paralinguistics; seminars in medical records and communication with colleagues; and sociocultural presentations. The language training methodology is based on the Rassias/Dartmouth Intensive Language Method of small-group instruction, and the Foreign Service Institute oral interview protocol is also used. Each FNMG participant conducts individual interviews with two simulated patients who have been trained to observe and evaluate physicians' communication skills, and videotapes of the simulated clinical encounters are reviewed immediately with the patient simulator and several other participants. Paralinguistic skills training addresses cross-cultural differences and common American practices with regard to kinesics, proxemics, and nonverbal utterances. Instruction is also provided on American culture, history, and sociology. Formative and summative evaluation measures of six June 1981 enrollees included pretest-posttest measures, language skills, and ratings of simulated clinical interviews. There was unanimous agreement that the program met individual needs and increased participants' oral language proficiency. Enrollees noted that the language training and patient simulation sessions were particularly valuable. Rating forms, the Foreign Service Institute's oral proficiency ratings, and sociocultural education topics listing are appended. (SW)

ED219010

SCOPE OF INTEREST NOTICE
~~The ERIC Facility~~ has assigned this document for processing to: HE FL
In our judgement, this document is also of interest to the clearinghouses noted to the right. Indexing should reflect their special points of view.

A TRAINING PROGRAM IN MEDICAL COMMUNICATIONS FOR FOREIGN NATIVE MEDICAL GRADUATES

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Comm. on Int. Ed.
Int. Med. Schools
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

NE 015 252

A paper presented at the annual meeting of the American Educational Research Association, New York, March 19 - 23, 1982

Supported in part by a grant from the Educational Commission for Foreign Medical Graduates

A Training Program in Medical Communications for Foreign Native Medical Graduates

RICHARD C. NEWBOLD, III, M.D.
The Committee for International Medical Exchange

J. GREGORY CARROLL, Ph.D.
University of Pennsylvania

MARY ELLEN HARTMAN, M.D.
Medical College of Pennsylvania

HOWARD E. MITCHELL, Ph.D.
The Wharton School
University of Pennsylvania

MARTHA R. STORY
The Committee for International Medical Exchange

Introduction

A number of significant educational needs have been identified in the literature on residency training for Foreign Native Medical Graduates (FNMGs). Haveliwala (1976), himself an FNMG, discusses some of the challenges facing psychiatric residents. There are significant problems in colloquial American language, differences in specialty knowedge, diagnostic procedures, trade name drugs, patient views of the doctor, understanding of national culture and history, problems of personal acculturation and discrimination, lack of sophistication in the health care system hindering entry into private practive and social distance from colleagues.

Knoff, et al (1976) have reported orientation programs conducted for FNMG psychiatry residents. The authors attribute some of these difficulties to misconceptions about the free-enterprise system with its myriad professional societies and regulatory agencies. Kim (1976) refers to the significant individual stress associated with the process of acculturation "including loneliness, rejection, misunderstanding and conflict."

Although the published literature principally describes the experience of psychiatry residents, the same problems are most certainly faced by other foreign residents. Language and cultural difficulties can seriously handicap FNMGs' personal adjustment and professional performance. These problems are brought into sharper focus in the doctor-patient relationship, beginning with the all important medical interview. Korsch, et al (1968), reported that patients perceive interpersonal barriers contributing to poor communication with physicians: a lack of warmth or empathy, a failure to recognize the patient's concerns and expectations, a lack of clear explanation of the causes of illness and an inappropriate use of medical terminology. Clearly, FNMGs are at a greater disadvantage than their American counterparts if their communications skills are further hindered by a lack of appropriate language and cultural competency.

While most authors in the medical literature cite communication problems arising from the foreign native medical graduate's lack of verbal and written American language skills, intercultural studies have emphasized the importance of pre-verbal or paralinguistic levels of communications. Given that rapport is a sine qua non for doctor-patient interaction, the foreign native medical graduate is, again, at a severe disadvantage if lacking appreciation and knowledge of this critical interpersonal dimension.

The objectives of this paper are (a) to describe an intensive three-week training program in medical communication skills for foreign native medical graduates (FNMGs) in preparation for residency training; (b) to present the design and methodology for evaluating the program and the participants' performance; (c) to summarize the preliminary results from the first pilot test of the program in June, 1981; and (d) to discuss the plans for program revision and implementation.

Methods and Techniques

An intensive three-week program in medical communications was designed during 1980-81 and tested by The Committee for International Medical Exchange. The major components of the program are described below.

1. Language and Acculturation Training (60 hours)

The language training methodology is based on the Rassias/Dartmouth Intensive Language Method of small-group instruction, which has previously been applied in intensive pre-medical and medical student training programs. Under this method, situational medically-related dialogues (created through "dialogue analysis" of actual clinical interviews) are presented in small-group morning sessions and memorized in class through choral and individual repetition and reinforcement. FNMG participants then manipulate the learned dialogues in role-play sessions. Motivation and interest remain high, since the pace is rapid, learning is kept relevant and materials are practically oriented and frequently varied.

The Foreign Service Institute oral interview protocol was selected insofar as it is the only reliable and valid speaking proficiency inventory available to our knowledge (see reference papers compiled for Testing Kit Workshop 3, School of Language Studies, Foreign Service Institute, September 3, 1980). The test is administered by two individuals: an interviewer and an evaluator. Both raters have native language proficiency and expert knowledge of the grammar in the language to be tested. The Foreign Service Institute oral interview procedure had not, prior to its application in our language program, been used to evaluate English-speaking proficiency; however, the raters performing the proficiency evaluations were trained in the protocol, consisting of a 20 to 25 minute face-to-face interview (see Appendix for copy of FSI oral evaluation training checklist).

2. Training in Clinical Interview Skills (43 hours)

The opportunity for repeated practice, observation and professional critique of one's clinical interview skills has been shown to be a crucial factor in the design of educational programs for improving doctor-patient communication skills (Carroll & Monroe, 1980). Patient simulation techniques

offer a particularly effective approach to the development of these communication skills, and previous research has demonstrated that simulated patients can be trained to provide specific and reliable feedback to medical students and housestaff (Stillman, et al., 1978; Stillman, Sabers, & Redfield, 1976, 1977).

In the FNMG training program, techniques of patient simulation have been adapted from an ongoing program designed to teach pediatric interviewing skills to medical students (Carroll, Schwartz & Ludwig, 1981). The FNMG program is introduced by a pediatrician who reviews a videotape of his own interview with a simulated patient. In this two-hour session, the pediatrician demonstrates the basic concepts and interview skills that are summarized on a rating scale adapted from the Arizona Clinical Interview Rating Scale (Stillman, et al, 1978) (see Appendix). During the three week program, each FNMG participant conducts individual interviews with two simulated patients who have been trained to observe and evaluate physicians' communication skills. Videotapes of the simulated clinical encounters are reviewed immediately with the patient simulator and several other participants. The simulator serves as an instructor to point out strengths and weaknesses in clinical interview technique. The simulator also completes the rating form for interview process skills and a checklist of interview content. (see Appendix). These results are discussed individually with the participants as part of the videotape critique process.

The same videotapes are viewed later in small groups with a clinical instructor. Here, participants compare the approaches of two different individuals to the same case. The clinical instructor points out how differences in the interview techniques may have led to differences in patient rapport or in the clinical data recorded.

For the June, 1981, pilot program, three simulators were trained to portray two clinical cases each. Six cases were developed from common problems in pediatrics (jaundice and rheumatic fever); gynecology (ectopic pregnancy); internal medicine (asthma and a combination of hypertension with adult onset diabetes mellitus); and psychiatry (depression). The simulators rehearsed their cases several times with the clinical instructors and were critiqued for accuracy and authenticity.

This simulation technique is designed to stress basic skills of doctor-patient communication, such as providing overt recognition and positive feedback, avoiding medical jargon, and explaining the underlying causes of illness. It is also designed to reinforce the participants' skills in verbal language, paralinguistics, and interview process in a setting which combines a high degree of realism with a low degree of anxiety and risk.

3. Paralinguistic Skills (19 hours)

There are non-verbal concommitants of verbal language identifiable in the behavior of participants in face-to-face encounters. Material on cross-cultural differences and common American practices with regard to kinesics, proxemics and non-verbal utterances is introduced, discussed and rehearsed both as a group and individually.

A cognitive examination to evaluate paralinguistic skills (non-verbal, vocal and non-verbal, non-vocal behaviors) was to have been developed as part of the project evaluation procedures; however, it became evident that evaluation procedures have simply not kept pace with the frontiers of knowledge and our consultants were unable to put together a protocol that measured these skills. A review of the literature, as well, proved fruitless.

4. New Residents' Seminar

(a) Medical Records (4 hours)

This seminar provided an introduction to medical records in United States health care institutions. Representative hospital forms and protocols for conducting/recording patient histories and physical examinations are provided to demonstrate the various components of hospital patient records and the modified problem-oriented patient record ("SOAP"). In addition, participants are required to write-up a simulated patient interview for review and commentary.

(b) Communication with Health Care Colleagues (10 hours)

This is a didactic seminar conducted by a senior resident in Internal Medicine, emphasizing accepted interpersonal protocol for interaction among health care colleagues, including methods for effective

verbal presentation of clinical cases. During the course of the Seminar, FNMG participants are encouraged to express their own concerns about residency.

5. Socio-Cultural Presentations (15 hours)

In the evenings of the final week, a series of didactic socio-cultural presentations is given in a lecture/discussion format. These presentations provide an overview of American culture, history and sociology. Public policy and attitudes are examined with regard to topics such as health care, poverty, unemployment and sex roles.

The purpose of this portion of the program was to provide an orientation to the socio-cultural fabric of the contemporary American situation in which these physicians will find themselves in practice during their stay in the United States. Prior to the first fifteen one-hour evening sessions, each participant was given a copy of Reflections of America, published by the U.S. Department of Commerce, Bureau of the Census. Reading assignments in the text were made in accordance with each lecture topic (see Appendix). With the exception of the first and last evening sessions, three topics were covered each evening.

Data Source

The preliminary data currently available are drawn from the first pilot test of the program with six (6) foreign native medical graduates in June, 1981. Ten FNMGs were enrolled in the program, having been recruited by direct mailing of informational materials to residency program directors in five mid-Atlantic states. Four FNMGs were unable to attend because of insufficient notice given them by their respective program directors. (Since the grant award was not made until March, a decision was made to conduct the program, even though recruitment would be greatly hindered by the lack of sufficient notice to enable hospitals to access their FNMGs in time for enrollment). The original program was designed for a total of 32 FNMG participants, to be divided as two sequential three week groups of 16 participants each. This design would allow for formative as well as summative evaluation. Given the small number of participants, the emphasis

of this pilot test was on formative evaluation for the training methods, content and materials (prior to a larger program planned for Spring, 1982). The design for formative evaluation focused primarily on measures of educational process. Methods include (a) daily orientation and "open forum" sessions to obtain informal feedback from the participants, (b) a group meeting of the participants, as well as individual exit interviews, during the final week of the program to elicit criticisms and suggestions for improving the program, (c) a questionnaire administered at the conclusion of the program to assess its strengths and weaknesses, and (d) telephone and personal interviews to be conducted with each participant several months after the program. The questionnaire contains 16 Likert-type statements with response categories of "Strongly Agree," "Somewhat Agree," "Somewhat Disagree," and "Strongly Disagree."

Preliminary data for summative evaluation were obtained in the form of (a) Foreign Service Institute (FSI) Oral Evaluations administered by a trained, external examiner, (b) ratings from trained simulated patients of the FNMGs' observed skills in clinical interviewing, and (c) a test of knowledge and attitudes related to selected topics on U.S. culture and society. These three measures were administered as pretests and posttests during the three week pilot program. In addition, the participants' communication skills and clinical performance were rated on a 12 item Likert-type scale by the directors of their respective residency training programs. These ratings were obtained approximately three months after completion of the pilot program. In the future, we plan to obtain longitudinal ratings from residency directors both for program participants and for a control group of non-participants in order to assess the program's impact upon house staff performance.

Given the small number of participants in this pilot program, the preliminary evaluation data have not been analyzed for statistical significance. Rather, the pretest-posttest scores of each individual participant have been compared, using each individual as his or her own control.

The FSI Oral Evaluations were conducted by a trained examiner who was not associated with the pilot program. However, it was not possible for the examiner to be kept blind to the pretest versus posttest condition, and this knowledge on the part of the examiner could have created an unintentional bias.

It should also be noted that the pretest and posttest observations of clinical interview skills were performed by the same three patient simulators using two different sets of clinical cases. The pretest cases were jaundice, asthma and diabetes mellitus with hypertension. The posttest cases were rheumatic fever, ectopic pregnancy and depression. Ratings of clinical interview skills have previously demonstrated considerable variability for the same interviewers across different clinical cases (Swanson, 1981). Furthermore, the interrater reliability of the simulators in this pilot study was not determined, and the simulators were aware of the pretest-posttest condition. A copy of the rating scale, which is a revision of the Arizona Clinical Interview Rating Scale (Carroll, Schwartz & Ludwig, 1981; Stillman, et al., 1978), is presented in the Appendix.

The knowledge test of socio-cultural factors consisted of 20 objective items. Ten items were multiple choice questions, and ten were true-false. The attitude scale on socio-cultural factors consisted of 15 statements. The respondents were asked to indicate their agreement or disagreement with each statement, using and eight-point scale from "Very Little" to "Very Great." Both instruments were developed specifically for this pilot program, and their reliability and validity have not been tested.

Results

The questionnaire results generally showed a strong endorsement of the overall program. The participants were unanimous in their Strong Agreement that the course was stimulating and interesting and that the instructors were active and well prepared. In addition, there was unanimous Agreement that the program was well organized, that it met their individual needs and increased their oral language proficiency; that the materials were adequate and appropriate; that the instructors were concerned about the FNMGs' progress; and that they, as participants, had gained confidence in relating to their work. There was slight disagreement among the participants about their improvement in written language proficiency and about the level of difficulty of the material (the emphasis of the language component was on teaching oral language skills, not written language).

In their oral comments, the participants noted that the language training and patient simulation sessions were particularly valuable and that the duration and scheduling of the program were appropriate, but there were several recommendations for a longer training period. Four of the six participants also indicated the desirability of additional language training in the form of short follow-up sessions during residency.

Preliminary results from the FSI language evaluation indicate that two participants entered the program with the equivalent of native fluency in English. (They had attended English-language schools in Asia, beginning at the primary school level). These participants were exempted from the language training sessions and were not retested, although they did attend approximately half of the language classes, on a voluntary basis, for the colloquial orientation to U.S. language and speech. The other four participants demonstrated measurable gains in fluency, accent and knowledge of colloquial speech (speaking and comprehension), as measured by the FSI grading scale from 0 to 5. The individual scores are shown in Table 1.

Table 1

Pretest and Posttest Scores on the FSI Oral Evaluation

Participant	Pretest Score	Posttest Score
1	3	4
2	2	2+
3	2	3
4	2	3+
5	5	N/A
6	5	N/A

Overall scores on the 11 item rating scale of clinical interview skills were obtained from the patient simulators' ratings of each participant. Two participants showed a decline in their total percent scores from the first to the second simulation sessions. Two participants showed minor improvement, and the other two demonstrated marked improvement. Overall, the mean scores for the two sessions showed an improvement of approximately 10%. These trends are complicated by variations in the clinical cases assigned to the participants for the first and second interviews, as discussed previously. The results are summarized in Table 2.

Table 2

Ratings of Observed Clinical Interview Skills in Two Patient Simulation Sessions

Participant	First Simulation(%)	Second Simulation(%)	Difference (%)
1	96.0	71.4	-24.6
2	65.7	52.7	-13.0
3	58.0	64.0	+ 6.0
4	61.8	76.0	+14.2
5	56.0	88.0	+32.0
6	46.0	89.1	+43.1
Mean	63.9	73.5	+ 9.6

The test results for participants' knowledge and attitudes related to U.S. culture and society are presented in Table 3. With the exception of trainees 4 and 6, the participants had little pre-training knowledge of socio-cultural America. Interestingly, Trainee 4 did not evidence any post training change, and Trainee 6 unfortunately was not available for the posttest. Trainee 5 also did not show a change from pretest to posttest. Trainees 1, 2 and 3 all showed positive change, and the average gain for the five trainees tested pre and post was 26%.

Five trainees demonstrated positive changes in attitudes; Trainee 6 was unavailable for the posttest. The average gain in pretest-posttest attitude scores was 30%.

Table 3

Knowledge of and Attitudes Toward U.S. Culture and Society

	Knowledge Scores (%)			Attitude Scores (%)		
Participant	Pretest	Posttest	Difference	Pretest	Posttest	Difference
1	10	50	+40	40	80	+40
2	10	30	+20	40	70	+30
3	10	80	+70	30	80	+50
4	50	50	0	50	70	+20
5	20	20	0	50	60	+10
6	40	N/A	---	50	N/A	---
	23.3	46.0	26.0	43.3	72.0	30.0

Discussion

Responses from the pilot program participants, along with the preliminary data reported on program outcomes, indicate that an expanded field test of the pre-residency program would be justified in 1982. It is anticipated that such a field test can be conducted with 30 to 40 FNMGs from residency programs in the Northeastern United States to determine how this program might serve as a model for the training of FNMGs entering residency nationally. As of July, 1981, this pool represents approximately 2,500 foreign native medical graduates, approximately 1,850 of whom may be expected to enter specialties intensive in direct patient care. Recent reconsideration of legislation and policies in both public and private sectors in the United States may well increase the numbers of FNMGs entering residency training programs in the near future. In fact, according to statistics supplied by the National Interns and Residents Match, as many as 6,000 to 7,000 FNMGs who have managed to obtain residency status in the United States may be participating in this year's matching program. In our estimation, such drastically increased numbers of FNMGs entering residency programs this coming June, 1982, makes such pre-residency orientation training all the more important.

Based on the experience and data of the pilot study, it may also become feasible to offer short follow-up courses and refresher sessions in collaboration with individual residency programs. This possibility will be explored in conjunction with the 1982 field study.

The field study is expected to provide an opportunity for extending the summative evaluation efforts of the program. It is hoped that a large enough sample of FNMGs will be available to test for statistical differences in the pretest-posttest scores of the FSI Oral Evaluation, the socio-cultural measures, and the ratings of clinical interview skills via simulated patients. To improve the process for measuring interview skills, we expect to conduct additional training of the simulators as raters or to hire and train other observers who will rate the interviews via videotape

and thus remain blind to the training condition of the individual participants being rated. We also plan to implement a counterbalanced schedule of clinical cases for the simulation sessions so that the overall distribution of cases will be comparable for the first and second series of simulation sessions.

Finally, we hope to have a sufficient pool of applicants for the field study to provide a control group of comparable FNMGs who do not participate in the pre-residency program. Ideally, this would represent a cohort of FNMGs who are interested in participating in the program but who are not able to enroll for the 1982 field test. Such a control group would provide a vital comparison for the pretest-posttest measures, such as the FSI evaluation, interview ratings and socio-cultural measures. The control group would be even more useful as a comparison for the ratings of residency program directors with regard to communication skills and clinical performance during residency training.

References

Argyle, M., Bodily Communcation. New York: International Universities Press, 1975.

Carroll, J.G. & Monroe, J. Teaching clinical interviewing in the health professions: A review of empirical research. Evaluation and the Health Professions, 1980 3, 21-45.

Carroll, J.G., Schwartz, M.W. & Ludwig, S. An evaluation of simulated Patients as instructors: Implications for teaching medical interview skills. Journal of Medical Education 1981, 56, 522-524.

Goffman, E. Relations in Public, London, Allen Lane, 1971.

Hall, E.T., Beyond Culture, Garden City, N.Y., Doubleday/Anchor, 1976.

Hall, E.T., The Hidden Dimension, New York, Doubleday/Anchor, 1966.

Hall, E.T., The Silent Language, Greenwich, Conn., Fawcett, 1959.

Haveliwala, Y., Problems of foreign born psychiatrists. Psychiatric Quarterly, 1979, 51,307-311.

Key, M.R., Paralinguistics and Kinesics, Metuchen, N.J., Scarecrow Press, 1975.

Kim, H.A., Transplantation of psychiatrists from foreign countries, Journal of the American Academy of Psychoanalysis,1976, 4, 112.

Knoff, H.F., et al., Meeting training needs of foreign psychiatric residents in state hospitals. Hospital and Community Psychiatry, 1976, 27, 35.

Korsch, B.M., Gozzi, E.K. & Francis, V., Gaps in doctor-patient communication. Pediatrics, 1968, 42, 855-871.

Poyatos, F., Man Beyond Words: Theory and Methodology of Nonverbal Communication. Monograph #15, New York State English Council, Oswego, N.Y. State University College at Oswego, 1976.

Stillman, P.L., Ruggill, J.S., Laguna, J.E. & Sabers, D.L., The Non-Physician in Medical Education. Tucson, Arizona: University of Arizona, College of Medicine, 1978.

Stillman, P.L., Sabers, D.L. & Redfield, D.L., The use of paraprofessionals to teach interviewing skills. Pediatrics, 1976, 57, 769-774.

Stillman, P.L., Sabers, D.L. & Redfield, D.L., Use of trained mothers to teach interviewing skills to first-year medical students: A follow-up study. Pediatrics, 1977, 66, 165-169.

Swanson, D.B., Mayewski, R.J., Norsen, L., Baran, G. & Mushlin, A.I. A psychometric study of measures of medical interviewing skills. Research in medical education, 1981. Proceedings of the twentieth annual conference. Washington, D.D.: Association of American Medical Colleges, 1981, pages 3-8.

ORAL PROFICIENCY RATINGS: FOREIGN SERVICE INSTITUTE

Proficiency ratings are determined on the basis of a 25-minute personal interview which approximates to some extent a social situation. The student is engaged first in a general conversation and then is encouraged to talk about activities or fields of special interest. As a result of the test, the student receives a rating on his speaking ability. These ratings are expressed by a number on a scale that runs from "0" (no practical knowledge) through "3" (comfortable control of the language, level required for an ambassadorial appointment).

The Checklist contains five factors: Grammar, Comprehension, Vocabulary, Fluency and Accent.

FACTORS IN SPEAKING PROFICIENCY

"0"	No knowledge	
"0+"	Grammar:	no syntactic control
	Comprehension:	severely limited, constant repetition necessary
	Vocabulary:	knowledge of about 30 words
	Fluency:	almost non-existent
	Accent:	wretched, almost exactly American
"1"	Grammar:	accuracy limited to set expressions; almost no control of syntax; often conveys wrong information
	Comprehension:	understands only very simple, familiar utterances

	Vocabulary:	adequate only for survival, travel, and basic courtesy needs
	Fluency:	except for memorized expressions, slow rate of speech
	Accent:	often unintelligible
"2"	Grammar:	fair control of most basic syntactic patterns; conveys meaning accurately in simple sentences most of the time
	Comprehension:	understands most non-technical speech directed to him, but sometimes misinterpretes or needs utternaces reworded; usually cannot follow conversation between native speakers
	Vocabulary:	adequate for simple social conversation and routine needs
	Fluency:	usually hesitant; often forced to silence by limitations of grammar and vocabulary
	Accent:	usually foreign, but rarely unintelligible
"3"	Grammar:	good control of most basic syntactic patterns; always conveys meaning accurately in reasonably complex sentences
	Comprehension:	understands almost everything said to him; can follow speeches, clear radio broadcasts, and conversation between native speakers, but not in great detail
	Vocabulary:	adequate for participation in all general conversation and for particular discussions in fields of special interests
	Fluency:	rarely hesitant; always able to sustain conversation through circumlocutions
	Accent:	sometimes foreign, but always intelligible

ASSIGNMENT OF "+" RATINGS:

"1+" Exceeds "1" primarily in vocabulary, and thus is able to meet more complex travel and courtesy requirements. Normally grammar is so weak that he cannot cope with social conversation because he frequently says things he does not intend to say (e.g., he may regularly confuse person, number, and tense in verbs). His accent and comprehension are generally poor. Fluency may vary, but even quite voluble speech cannot compensate for all the other serious weaknesses.

"2+" Exceeds "2" primarily in fluency and in either grammar or vocabulary. Blatant deficiencies in one of these latter factors or general weakness in both usually prevent assignment of a rating of "3." If a student has a "3+" rating in vocabulary, fluency, and comprhension, and if his grammatical errors do not interfere with understanding, he should be awarded a "3," not a "2+."

"3+" Exceeds a "3" rating primarily in vocabulary and in fluency or grammar. The kind of hesitancy that indicates uncertainty or effort in speech will normally prevent the assignment of a higher score, although the student's way of speaking his native language should be checked in doubtful cases. Frequent grammatical errors also must limit the rating to a "3+," no matter how excellent the accent, fluency, vocabulary, and comprehension.

Rating Scale for Simulated Interviews

Student _____

Simulator _____

Case (Complaint) _____

_____

Date _____

or each item below, circle the appropriate number:

ART ONE: ESTABLISHING AND MAINTAINING A WORKING RELATIONSHIP

I. JOINING STATEMENTS

5	4	3	2	1
ne interviewer makes a oint of "joining" with ne patient personally, .g., comments on patient's ppearance, inquires about etting to office. Inter- iewer introduces self and emonstrates concern that he patient feel at ease.		The interviewer makes some general introductory comments before discussing chief complaint.		The interviewer makes no effort to get acquainted with the patient. The interview begins abruptly with medical history.

II. SENSITIVE AREAS

5	4	3	2	1	N
The interviewer demonstrates tact and concern for the patient in discussing sensi- ve areas (e.g., letting the patient determine the ce of the discussion in nese areas).		The interviewer recognizes sensitive areas but fails to explore them in sufficient depth or to discuss them with tact or concern.		The interviewer consistently avoids discussing sensitive areas that are pertinent.	

III. RECOGNITION AND FEEDBACK

5	4	3	2	1
The interviewer provides the patient with overt positive feedback, e.g., commending the patient for proper health care techniques.		The interviewer provides recognition and feedback only to the extent expected in normal conversation, e.g., an occasional smile, nodding of the head.		The interviewer provides the patient with little support or positive feedback. Stress is on negative rather than positive attributes of the patient.

IV. PATIENT CONCERNS

5	4	3	2	1
The interviewer seems alert, sensitive and responsive to possible concerns expressed by the patient regardless of whether such concerns are immediately relevant to the patient's present problems, e.g., child discipline problems, depression. The interviewer explores these concerns in sufficient depth.		The interviewer detects possibly unrelated concerns expressed by the patient but fails to explore them in sufficient depth.		The interviewer seems unalert or insensitive to possibly unrelated concerns expressed by the patient. For whatever reasons the interviewer tends to avoid discussing possible problem areas which could have either immediate or future implications for the mental or physical health of the patient.

PART TWO: DATA ELICITATION

V. QUESTIONS GENERALLY UNDERSTANDABLE

5	4	3	2	1
The interviewer asks questions that are clear, concise, and free of difficult medical terms and jargon inadequately defined for the patient.		The interviewer sometimes asks multiple questions, uses unnecessary jargon, or fails to articulate questions clearly.		Questions are generally confusing and difficult to understand; unnecessary jargon is used frequently.

VI. OPEN-END QUESTIONS

5	4	3	2	1
eliciting information from patient, the interviewer ins with open-ended ques- ns. Closed questions are d subsequently as needed clarify, extend, probe, confirm information.		The interviewer uses open-ended questions but also employs leading questions, e.g., "Your child has never had diarrhea, has he?"		The interviewer asks only leading questions and closed questions.

VII. CLARIFICATION/DOCUMENTATION OF DATA

5	4	3	2	1
e interviewer seeks rification and docu- tation of vague terms t could imply impor- t information, e.g., at do you mean by nstipation," "What na of allergic reac- on?"		The interviewer sometimes fails to have the patient define vague or subjective terms. The interviewer is sometimes misled by accepting statements at face value.		The interviewer routinely accepts vague terms without further clarification. The interviewer simply accepts information at face value.

VIII. INTERVIEW FOCUS

5	4	3	2	1
e interviewer helps the tient "tell the story" th an appropriate ount of direction.		The interviewer skillfully guides the interview much of the time. At some points, however, there are extended digressions by the patient and/or interviewer.		The interviewer interrupts or misleads the patient, thereby blocking the flow of relevant data.

PT THREE: CLOSURE

IX. SUMMARY OF DATA

5	4	3	2	1
the end of the inter- ew, the interviewer views fully the pa- ent's clinical data, lowing him/her to firm or disaffirm e data.		At the end of the interview, the interviewer reviews some of the patient's clinical data but does not give sufficient opportunity for the patient to respond.		At the end of the interview the interviewer makes no attempt to summarize the information.

X. EXPLANATION OF UNDERLYING CAUSES

5	4	3	2	1
the end of the inter- ew, the interviewer plains fully, to the best his or her ability, e underlying causes the clinical problems, king sure that the pa- ent understands the planation.		At the end of the interview, the interviewer offers incomplete or confusing explanation of the underlying causes.		At the end of the interview, the interviewer offers no explanation of the underlying causes.

XI. OPPORTUNITY FOR ADDITIONAL DISCUSSION

5	4	3	2	1
the end of the inter- ew, the interviewer ex- plicitly encourages the tient to discuss any ditional questions; the terviewer makes a sin- re effort to address en points or questions.		At the end of the interview, the interviewer makes a token effort to address any additional points or questions the patient may want to raise, e.g., "Any questions?"		At the end of the interview, the interviewer does not provide the patient the opportunity to discuss any additional points or ask any additional questions.

SIMULATOR FORM

Simulator: Ben Sweetwood

Basic Information: Headache/Depression

Student: _____

Date: _____

I. Identification

_____ 1. Name

_____ 2. Age

II. Chief Complaint

_____ 1. Headache

_____ 2. Depression

III. Patient Profile

_____ 1. Family

_____ 2. Occupation

_____ 3. Family's medical history

IV. Present History

_____ 1. Type of pain

_____ 2. Location of pain

_____ 3. Any radiation of pain

_____ 4. Associated symptoms, i.e., fainting, feverish chills, stiffness of neck

_____ 5. Any problems with vision

_____ 6. Any problems with mentation

_____ 7. Has patient been eating normally

_____ 8. Any previous episodes of similar pain

_____ 9. Any past history of previous mental condition

_____ 10. Any inciting event known, past or present

_____ 11. Medications

_____ 12. Past history of surgery

_____ 13. Past history of trauma

_____ 14. Any recent illness

_____ 15. Feeling "low in spirits", "blue", "glum", "unhappy or morbid"

_____ 16. Fatigue, loss of "pep", weak, tired, no energy to work

_____ 17. Problem with employment

_____ 18. Uncontrolled worry over trivialities

_____ 19. Any hypochondriacal ideations, i.e., arthralgia, toothache, abdominal pains, frequency of urination, insomnia, pruritis, burning tongue, weight loss

_____ 20. Changes in sleeping pattern

_____ 21. Changes in eating pattern

_____ 22. Change in relationship with family/friends

V. Social History

_____ 1. Smoking

_____ 2. Drugs

_____ 3. Ethanol intake (alcohol)

VI. Allergies

_____ 1. Any known drug allergies

VII. Family Medical History

_____ 1. Father: Alive? Dead? Any chronic disease?

_____ 2. Mother: " " " " "

_____ 3. Siblings: " " " " "

VIII. Past Medical History

_____ 1. Previous surgery

_____ 2. Previous medical admissions

IX. Medications

_____ 1. Recent change in medications

_____ 2. Use of steroids

X. Diseases of Childhood/Adult Diseases

_____ 1. Description

_____ 2. History of TB, Rheumatic Fever, etc.

XI. Review of Systems

_____

RESIDENCY DIRECTORS

RATINGS OF RESIDENTS' COMMUNICATION SKILLS

Please rate Dr._____according to the performance to date on each of the items listed below. Your assessment is needed for evaluation of our educational program only. No individual data will be reported for program participants; only aggregate data will be reported.

For each of the following items, please rate this particular resident in comparison to all other residents you have trained and observed, according to the following scale.

Outstanding	- among top 20% of all residents observed
Strong	- in the range of 60% to 80% of all residents
Average	- in the middle 20% of the range (40% to 60%)
Weak	- in the range of 20% to 40% of all residents
Poor	- among lowest 20% of all residents observed

(check the appropriate category)		Poor (0-20%)	Weak (20-40%)	Average (40-60%)	Strong (60-80%)	Out-Standing (80-100%)
I. Communication with Patients:						
1. Ability to elicit clear and concise clinical history	1.					
2. Sensitivity to patients' concerns; ability to identify hidden concerns and questions	2.					
3. Ability to inspire confidence and trust and to put patients at ease	3.					
4. Ability to intervene effectively and to explain clearly the plans and options for case management	4.					
II. Communication with Colleagues:						
1. Ability to present a case clearly and discuss appropriate plans for diagnostic testing and management	1.					

(check the appropriate category)		Poor (0-20%)	Weak (20-40%)	Average (40-60%)	Strong (60-30%)	Cut-standing (30-100%)
II. Communication with Colleagues: (continued)						
2. Ability to speak effectively in daily interactions with attending physicians, residents, nursing staff, hospital staff and students	2.	_____	_____	_____	_____	_____
3. Ability to communicate clearly through written correspondence, patient charts, hospital records and reports	3.	_____	_____	_____	_____	_____
III Overall Clinical Performance:						
1. ability to diagnose clinical problems accurately	1.	_____	_____	_____	_____	_____
2. Ability to plan and manage appropriate forms of treatment	2.	_____	_____	_____	_____	_____
3. Ability to exercise sound clinical judgment	3.	_____	_____	_____	_____	_____

(check the appropriate category)	Poor (0-20%)	Weak (20-40%)	Average (40-60%)	Strong (60-80%)	Out-standing (90-100%)

III. Overall Clinical Performance: (continued)

4. Ability to provide effective patient counseling and patient evaluation 4. _____ _____ _____ _____ _____

5. Ability to relate effectively to patient families 5. _____ _____ _____ _____ _____

IV. Comments:

Socio-Cultural Orientation Lectures
CIME/ECFMG Program

Date	Lecture Number	Topic and Reading Assignment
6/13	1	Overview and Objective of Socio-Cultural Series (pp. 1-4)
	2	Population Changes and American Cities (pp. 143-152; pp. 35-42)
	3	Business and The American Economy (pp. 27-34; 97-104)
6/15	4	Housing Issues in the United States (pp. 113-120)
	5	The Arts, Their Growth and Health (pp. 15-20)
	6	Transportation (pp. 167-176)
6/16	7	The Assimilation of Minorities (pp. 133-152; 43-50)
	8	The Status of Women (pp. 183-192)
	9	Education: Its Promise and Problems (pp. 91-96)
6/17	10	Hispanic America: Family Structure and Folkways
	11	Poverty and The War That Was Not Fought (pp. 153-156)
	12	Crime and Violence (pp. 65-74)
	13	Civil Rights and Voting (pp. 21-26; pp. 177-182)
6/18	14	The Consumer Movement in America
	15	Understanding Organizational Behavior in U.S.